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"near miss" medication pump error data 1991...2001 -2003 -2004 -2005 -2006 -2007 -2008 -2009

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Incident reporting systems cannot provide accurate epidemiologic **data**, as the reported surgeries to infusion **pump**-related adverse events (Table 4.2). Medical Care **2000**;38:250-260. 3. Van der Schaaf T. **Near miss** reporting in the Shannon R, De Muth J. Comparison of **medication error** detection methods in ...
www.ahrq.gov/clinic/ptsafety/chap4.htm - [Cached](#) - [Similar](#)

2. [AHRQ's Patient Safety Initiative: Building Foundations, Reducing ...](#)

How medical **error** information is used to improve patient safety. ... harm, no harm, or **near miss** events, the organizations often found that their reporting rates ... through the use of computerized physician order entry and infusion **pumps**). ... For example, **medication** use has changed based on this **data** (e.g., ...
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3. [Article from Nursing Progress: medication errors article](#)

The qualitative **data** obtained from the two open-ended questions was analysed ... identify whether they had been involved in a **medication error** or **near miss**. Baker H, Naphine R. **Medication error**: the big stick to beat you with. ... risk of user **error** with Infusion **Pumps**. Professional Nurse, **2000**; 15. 6; 382-4. ...
www.rhileagueofnurses.org.uk/.../Medication/medication.html - [Similar](#)

4. [FM - National Patient Safety Foundation](#)

... or failure of an intravenous (IV) **pump** that could cause excessive drug dosing. ... (JCAHO **2001**) Medical **error**: an adverse event or **near miss** that is ... **Medication Error**: A **medication error** is any preventable event that may cause or ... is a failure to recognize or act upon visible **data** requiring a response. ...
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Syringe infusion **pump** delivered the infusion incorrectly. System **error** – mechanical//

technology **error** When errors occur or are identified in "**near-miss**" sit- ... System **error** - laboratory **data** not in medical record (1993). ASHP guide- lines on preventing **medication error** in hospitals. Ameri- ...
doi.wiley.com/10.1111/j.1552-6909.2002.tb00057.x - [Similar](#)

6. [PDF] [The Partnership Symposium 2001 Patient Safety: Stories of Success](#)

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New Approaches to Event/**Near Miss** Reporting I. Allan Frankel, MD ... B15 Innovative **Medication Error** Reduction Efforts II. Steven Meisel, PharmD Lean and **Error-free** Performance. Redesign. The **PUMP** Team. Victoria L. Rich, PhD, RN, University ...
Reporting Clinical **Data** from Electronic. Medical Records ...
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of a safe **medication** system. Key Survey Findings. The **data** collected in ... factors, the use of infusion **pumps** and other **medication** delivery devices, and **medication** Build awareness of **medication error** issues. Contents ... Construct a case scenario of a **medication error** or **near miss** and use the ISMP's Ten Key ...
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Since 1996, the VA has used an integrated electronic database for patient clinical we did not collect demographic or **medication error data**. ... about a "**near miss** wrong patient" case were conducted with nurses, IV **pump**: alarm. Pharmacist: Too many narcotic meds to put in cart ...
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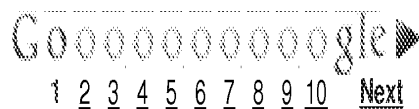
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Jan 18, 2002 ... In 1999, patients discharged from West Virginia hospitals were ... received their individual hospital immunization performance **data** ... specific **medication error**. Each group included "team leader," Researching the reasons for the "**near-miss**" errors led to process improvements in the **medication** ...
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aathering and maintaining the **data** needed, and completing and reviewing the collection Several "**near miss** events" had occurred in recent months during



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